STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005033	A. BUILDING: _____ B. WING _____	12/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTER REGIONAL HOSPITAL	85 EAST US HWY 6 VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This survey was for the investigation of one State complaint. Complaint number: #IN 00147954: Unsubstantiated; lack of sufficient evidence. Date of survey: 12/2/2014 Facility: 005033 Surveyor: Nancy Otten, RN Public Health Nurse Surveyor Porter Regional Hospital is in compliance with 410 IAC15-1.5-5, Medical Staff, Hospital Licensure Rules. QA: claughlin 01/27/15	S 000		